ADVANCE HEALTH-CARE DIRECTIVE

OF

Leroy White

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care.

PART 1 allows you to name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator or employee of a residential long-term health-care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;

(b) Select or discharge health-care providers and institutions;

(c) Approve or disapprove diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and

(d) Direct the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

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North Mississippi Rural Legal
5 County Rd. 104 P.O. Box 767
Oxford, MS 38655 - 1800-898-8731

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PART 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

PART 3 of this form lets you designate a physician to have primary responsibility for your health care.

PART 4 of this form is a Certificate of Authorization for Organ Donation. This Addendum allows you to authorize the donation of your organs at your death, and declares that this decision will supersede any decision by a member of your family.

After completing this form, sign and date the form at the end and have the form witnessed by one of the two alternative methods listed below. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

ADVANCED HEALTH CARE DIRECTIVE

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

(1) **DESIGNATION OF AGENT:** I, Leroy White, designate the following individual as my agent to make health-care decisions for me:

Name of Primary Agent	Victoria Lee, Daughter
Address of Primary Agent	5624 Wayne Cove, Horn Lake, Mississippi 38637
Work Phone	
Home Phone	(901) 219-0934 (cell); (662) 781-5229 (home)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

Name of First Alternate Agent	Eric D. Lee, Son-in-law
Address of First Alternate Agent	5624 Wayne Cove, Horn Lake, Mississippi 38637
Work Phone	
Home Phone	(662) 781-5229 (home)

(2) **AGENT'S AUTHORITY:** My agent is authorized to make all health-care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:

_____

_____

(3) **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:** My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health-care decisions for me takes effect immediately.

(4) **AGENT'S OBLIGATION:** My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) **NOMINATION OF GUARDIAN:** If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as guardian, I nominate the alternate agent(s) whom I have named, in the order designated.

(6) **HIPAA RELEASE AUTHORITY:** I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (also known as HIPAA), 42 USC 1320d and 45 CFR 160-164. I authorize:

a. Any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health company and the Medical Information Bureau Inc. or other health-care clearing house that has provided treatment or services to me or that has paid for or is seeking payment from me for such services;

b. All of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, to include all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse.

The authority given to my agent shall supercede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The authority given to my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health-care provider.

PART 2: INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(7) END-OF-LIFE DECISIONS: I direct that my health-care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

[ ](a) Choice Not To Prolong Life

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time; (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness; or (iii) the likely risks and burdens of treatment would outweigh the expected benefits.

[ ](b) Choice to Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(8) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (7) unless I mark the following box,[ ]. If I mark this box [ ], artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I made in paragraph (7).

(9) RELIEF FROM PAIN: I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death, except as I state in the following space:

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(10) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that: My agent have control over end of life decisions and make such decisions in accordance with my values.

His mark X Leroy White

(Add additional sheets if needed.) Witnesses: Karen B. Gamson

Catherine V. Kilgore

PART 3: PRIMARY PHYSICIAN(OPTIONAL)

(11) I designate the following physician as my primary physician:

Name of Primary Physician	Curtis Owens, MD
Address of Primary Physician	Delta Medical Center, 3960 Knight Arnold Road #200, Memphis, Tennessee 38118
Work Phone	(901) 369-6095
Home Phone	

(OPTIONAL) If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Name of Primary Physician	
Address of Primary Physician	
Work Phone	
Home Phone	

PART4: CERTIFICATION OF AUTHORIZATION FOR ORGAN DONATION

I, the undersigned, this _____ day of _____, 20____, desire that my _____ organ(s) be made available after my demise for:

a. any licensed hospital, surgeon or physician for medical education, research advancement of medical science, therapy or transplantation to individuals;
b. Any accredited medical education or research, for therapy, educational research or medical science purposes or any accredited school or mortuary science;
c. Any person operating a bank or storage facility for blood, arteries, eyes, pituitaries, or other human parts, for use in medical education, research,

therapy or transplantation to individuals.

d. The donee specified below, for therapy or transplantation needed by him or her, do not donate my _____ for that purpose to _____(name) at _____ (address)
I authorize a licensed physician or surgeon to remove and preserve for use my _____ for the above stated purpose(s).

I specifically provide that this declaration shall supersede and take precedence over any decision by my family to the contrary.

PART 5: MISCELLANEOUS PROVISIONS

(12) DURABILITY: This Advance Health-care shall not be affected by the subsequent disability or incapacity of the principle, or lapse of time.

(13) REVOCATION OF PRIOR DIRECTIVES: I hereby expressly revoke and all Advance Health-care directives and organ and/or tissue donation directives heretofore given by me.

(14) EFFECT OF COPY: A copy of this form has the same effect as the original.

(15) SIGNATURES: Sign and date the form here:

2/6/09
(Date)

His mark Leroy White
(Sign Your Name)

Witnesses: Kevin B. Garrison
Calliecia V. Kelgore

LEROY White
(Print Name)

5624 Wayne Cove
Address

Horn Lake, MS 38637

WITNESSES

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this Power of Attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility. **I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon death of the principal under a will now existing or by operation of law.**

Catherine V. Kilgore — 2-6-09
(**Non-relative** Witness #1 sign your name) — Date

Catherine V. Kilgore
(Print your name)

P. O. Box 664
Address

Oxford, MS 38655

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this Power of Attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider, nor an employee of a health care provider or facility.

Kevin B. Garrison — 2/6/09
Witness #2 sign your name) — Date

Kevin B. Garrison
(Print your name)

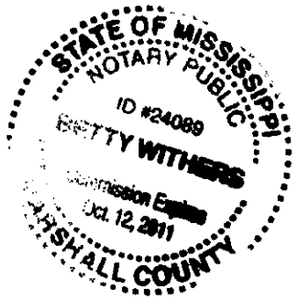
822 University Avenue
Address

Oxford, Mississippi 38655

STATE OF MISSISSIPPI

COUNTY OF DESOTO

On this the 6th day of February, in the year Two-thousand and nine, before the undersigned duly appointed Notary Public in and for the jurisdiction aforesaid, the within named Leroy White personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.



Betty Withers
NOTARY PUBLIC

My Commission expires: 10/12/2011

return to:
* Leroy White
5624 Wayne Cv.
Horn Lake, MS 38637